

EXHIBIT A

INSTRUCTIONS:
Place only ONE letter or number in each space
and leave a blank space between words.

CIVIL COURT OF THE CITY OF NEW YORK
SMALL CLAIMS PART
STATEMENT OF CLAIM

(FOR OFFICE USE ONLY)

I. CLAIMANT'S INFORMATION

(Your)
LAST NAME HERSKOVIC
FIRST NAME YEHUDA
ADDRESS (NO P.O. BOX) 225 ROSS ST
BOROUGH, CITY, TOWN OR VILL. BROOKLYN STATE NY ZIP 11211
OTHER INFO
[Doing Business As] [In Care Of]
[Attention To] Circle One PHONE NO. 347 731 8818

II. DEFENDANT'S INFORMATION*

(Their)
LAST NAME TAP AIR PORTUGAL / PORTUGAL US CHAMBER - COMMERCE
FIRST NAME
ADDRESS (NO P.O. BOX) 590 5TH AVE #4
BOROUGH, CITY, TOWN OR VILL. NEW YORK STATE NY ZIP 10036
OTHER INFO PORTUGAL US CHAMBER - COMMERCE
[Doing Business As] [In Care Of]
[Attention To] Circle One PHONE NO. 212 354 4627

III. CLAIM

Amount Claimed: \$ 990 (Maximum \$5,000)

Date of Occurrence or Transaction: 05/06/2019

Place of occurrence, if Auto Accident

PRIMARY REASON FOR CLAIM (Check One):

Damage caused to:	automobile	other personal property	real property	person
Failure to provide:	proper repairs	proper services	proper merchandise	goods paid for
Failure to return:	security	property	deposit	money loaned
Failure to pay:	salary	for services rendered	insurance claim	
	rent	commissions	for goods sold and delivered	
Breach of:	contract	lease	warranty	agreement
Loss of:	luggage	property	time from work	use of property
Returned:	check (bounced)	check (stopped)		
Other: (Be brief)	<u>OVER CHARGED MY CREDIT CARD & DIDN'T PROVIDE PROPER SERVICE</u>			

IDENTIFYING NUMBER(S) - (Receipt #, Claim #, Account #, Policy #, Ticket #, License #, Plate # (s))

08/13/2019
Today's Date

[Signature]
Signature of Claimant or Agent

* DEFENDANT'S NAME: The legal name will be required in order to obtain an enforceable judgment. If the Defendant is a business, its full and correct business name should be obtained from the Office of the County Clerk in the county in which the business is located or check on the following website: www.dos.state.ny.us.
DEFENDANT'S ADDRESS: YOU must indicate the proper street address of the Defendant. A Post Office Box is not acceptable.

CERT'D #

COA CODE

CLAIM AMT.

FEE

STANDARD FEE

☐ CLAIMANT V. DEFENDANT

NO FEE

☐ DEFENDANT V. THIRD PARTY

☐ CLAIMANT V. ADD'L DEFENDANT

POSTAGE ONLY

☐ WAGE CLAIM TO \$300

LANGUAGE

DATE DATA ENTERED

DATE NOTICES MAILED

CASE TYPE:

MULTI DFT ☐ CTR/CLM ☐

3 PARTY ☐ CRS/CMPLT ☐

FIRST DATE

DAY COURT

☐ STATUTORY ☐ OTHER

FREE CIVIL COURT FORM

No fee may be charged to fill in this form.

Form can be found at